Montana Medicaid CLAIM JUMPER

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Children's Special Needs Screening Begins in September

Montana Medicaid is excited to announce another new feature that will benefit PASSPORT To Health providers and their clients. Screening for children with special health care needs (CSHCN) will help identify young clients who have chronic and/or complex physical, developmental, behavioral, or emotional conditions.

Beginning next month, Montana Medicaid's Help Line and enrollment broker will begin gathering this information from clients new to the program. Information will be gathered regarding:

- Prescription medication usage;
- Frequency of medical care, mental health, or educational services;
- Limitations in normal activities;
- Usage of physical, occupational, or speech therapies; and
- Usage of treatment or counseling services

This data will then be sent to the client's PASSPORT provider. While clients will supply CSHCN information on a voluntary basis, the PASSPORT program expects this new tool will be beneficial to the provider and the client as well. Montana Medicaid believes this screener will help the client establish a strong and compassionate medical home more quickly, thereby receiving appropriate, medically necessary services at the right time. In the future, usage of the CSHCN screener may be expanded to include children currently enrolled in PASSPORT.

For more information about CSHCN screening, contact PASSPORT Program Officer Niki Scoffield at (406) 444-4148 or niscoffield@mt.gov.

Submitted by Anastasia Burtion, DPHHS

Passing the Mail Room Screening

When claims arrive for processing, their first stop is the mailroom. Here they are screened for certain necessary information before being batched, imaged, and sent for processing. To ensure that your claims pass the mailroom pre-screening, you must verify that the following information is present and accurate:

- Provider Signature in box 31
- Bill date after last date of service in Box 31
- Provider ID number in box 33

If any of this information is missing, the mailroom will return the claim to your office so that it can be corrected and billed again. Ensuring that the information is present and correct will ensure a smoother processing of your claim.

Submitted by ACS

Vaccines for Children

There has been a change in Vaccines for Children (VFC). The VFC codes as of dates of service July 1, 2005 and after are:

90633, 90645, 90647, 90648, 90655, 90656, 90657, 90658, 90669, 90700, 90707, 90713, 90714, 90716, 90718, 90723, 90732, 90744, 90743 and 90748.

Submitted by Doug Girard, DPPHS

Revised Processing for Emergency Room Visits

Montana Medicaid recently made changes to the claims processing system to recognize claims for recipients who are under 2 years of age and are seen in the emergency room after hours, on weekends, and major holidays as emergency services. These changes apply to claims that have a first date of service on or after January 1, 2005. In addition, there are now procedure codes that will always be considered emergent, regardless of recipient age. The 'always emergent' procedures apply to claims with first date of service on or after January 1, 2005, with several procedures effective August 1, 2003. These updates became effective in early July, and a mass adjustment will be processed to correct the claims processed prior to this policy change. Previously, claims that met these conditions

would have to be submitted to Medicaid for review and pricing. Now the claims processing system has been updated to recognize claims as emergency services if they meet the following criteria:

For professional claims:
If the client is under 2 years old and is seen in the emergency room, and the date of services is on a weekend, or on January 1, July 4, or December 25, then the claim will be considered and processed as emergent. If the client is under 2 and is seen in the emergency room on a weekday outside or regular office hours and the claim contains procedure code 99050 (services requested after posted office hours in addition to basic service), then the claim will be considered and processed as an emergency. This procedure code is set to bundle, and the provider should bill this code with zero charges. In addition, cost share will not be taken on these claims.

Another change is the addition of procedure codes that are always considered emergent in an emergency room setting, regardless of age. Lines with the same date of service as one of these procedures will be considered an emergency, and cost share will be overridden. This procedure list can be found on www.mtmedicaid.org.

For institutional claims:
If the client is under 2 years old as of the first covered day on the claim, and the service is performed in the emergency room between 6 pm and 8 am, or at any hour on a weekend (Saturday or Sunday), or on January 1, July 4, or December 25 the claim will be considered an emergency and priced accordingly. In addition cost share will not be taken. Claims that reflect more than one emergency department visit in a 72-hour period should not be span billed on one claim. In order for you to be properly reimbursed for each visit, separate claims must be submitted for each visit. In the case where one client has two visits on the same day, the second claim must be submitted to Rena Steyaert (Health Policy and Services Division, P.O. Box 202951, 1400 Broadway, Helena, MT 59620-2951) for review.

Please note this material does not apply to Montana's critical access and exempt hospital claims because their claims bypass the emergent services list and receive payment for emergency room visits based on their cost to charge ratio.

Submitted by ACS

Tips for Processing with OCR

During April paper claims received by Medicaid began to be processed using an Optical Character Recognition system (OCR). CMS 1500 claims began in April and UB92 claims were added to OCR in late July. The OCR process uses a computer to 'read' the information from the claim instead of being manually data entered. This process improves accuracy and increases the speed at which claims are entered into the claims processing system.

One major change that providers will notice is the amount of time claims are in suspense. Prior to the implementation of the OCR solution paper claims were entered into the claims processing system approximately three weeks after they were received. Then a majority of the suspense was resolved at the time of entry. With the OCR solution paper claims are normally entered within one week of receipt and no suspense is resolved at the time of entry. This causes claims to appear on the SOR much faster than without OCR. Claims that were previously held as unkeyed on a shelf are now being held in a pended status in the claims processing system. Once the exceptions have been resolved the claims will be reported as paid or denied on the SOR.

The following list of Dos and Don'ts will aid you in decreasing processing times for paper claims.

Do

- Use an original, standard red-dropout form (HCFA, UB, etc.)
- Use machine (typewritten) print
- Use a clean, non-proportional font
- Use black ink
- Print claim data within the defined boxes on the claim form
- Print only the information asked for on the claim
- Use all capital letters
- Use a laser printer for best results
- Use white correction tape for corrections
- Submit notes on 8½" x 11" paper
- Use an 8-digit date format (e.g., 10212004)

Don't

- Don't use stamps, labels, or stickers
- Don't include narrative comments in diagnosis fields
- Don't hand print or hand write your forms; if you must hand print, use neat block letters that stay within field boundaries
- Don't use copies of claim forms
- Don't use dashes or slashes in date fields.
- Don't use fonts smaller than 8 point
- Don't use a dot matrix/impact printer, if possible
- Don't use correction fluid
- Don't put notes on the top or bottom of the claim form
- Don't enter "none", "NA" or "Same" if there is no information; just leave the box blank
- Don't fold claim forms
- Don't use proportional fonts (Courier is a good example of a font that is not proportional)
- Don't use mixed fonts on the same form
- Don't use italics or script fonts
- Don't print slashed zeros
- Don't use highlighters to highlight field information

Submitted by ACS

PA Rejections

Recently our EDI Call Center has received several calls about Prior Authorization (PA) numbers not coming through on electronic claims. Providers are entering in the PA in the electronic claim, but the number is not passing over to

the payer when the claims are reviewed for payment and are being denied. Why? In the Subscriber Information section of the claim, if anything other than Medicaid is selected as the Claim Filing Indicator Code the number will not come through. Please note: if the patient has TPL you will need to indicate Medicaid as secondary and enter the PA in the appropriate fields. The PA number is restricted to Medicaid and the system does not recognize other carrier Prior Authorization numbers. Since other numbers are not recognized, this will cause the number/information to not carry over to the appropriate field.

For example: Loop 2000B, segment SBR, element P for primary if Medicaid is their primary insurance, and MC to indicate Medicaid. And remember, use Loop 2300, REF, 01, qualifier G1 to indicate you are submitting a PA number and REF 02 for the PA number.

If you have any questions, or are having any trouble with your electronic claims, please contact our EDI Technical Support Unit at 1-800-624-3958 (Montana) or 406-442-1837 (Helena and out of state.)

Submitted by ACS

Changes to the Website

If you have been on the Medicaid website recently, you may have noticed some changes. There is a new option titled Provider Services. Beginning September, 2005, providers will be able to select this option to verify client eligibility and check status of a claim. Additional options will be added in phases, and will allow providers to enroll with Medicaid online, verify the status of a warrant, read their remittance advice, and even submit claims to Medicaid. Primary care physicians will be able to view clients' medical history.

Eligibility and claim status may be requested for a single client with real-time response, or requests can be submitted in batches with HIPAA compliant responses available within 24 hours. User IDs are designed to allow providers to manage their organization's user access for maximum security.

In addition to the existing provider resources available at mtmedicaid.org, the new provider services will save providers time with the convenience of a "one-stop" Medicaid resource center. These options will be released in phases, so watch upcoming issues of the Montana Medicaid Claim Jumper, and visit mtmedicaid.org frequently.

Submitted by ACS

Recent Publications

The following are brief summaries of recently published Medicaid information and updates. For details and further instructions, download the complete document from the Provider Information website at www.mtmedicaid.org. Select ***Resources by Provider Type*** for a list of resources specific to your provider type. If you cannot access the information, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Recent Publications Available on Website		
Date	**Provider Type**	**Description**
Fee Schedules		
06/30/05	Hospital Outpatient	Updated Fee Schedule and APC Schedule
Other Resources		
06/13/05	All Providers	Article on the new Web Portal coming soon
06/13/05	All Providers	May Claim Jumper Newsletter
06/15/05	Pharmacy	Updated PDL Quicklist
06/22/05	PASSPORT to Health	Summit Pictures and Text from Kalispell and Missoula
06/22/05	Home Health	Home Health Initial Authorization Form
06/22/05	Home Health	Extended Services PA Form
06/24/05	Hospital Outpatient	Manual Replacement Pages and Updated Manual
06/29/05	Pharmacy	Updated PDL Quicklist
06/30/05	All Providers	Added New DPHHS Header
07/05/05	Pharmacy	Updated PDL and Quicklist
07/07/05	Dentists and Denturists	Updated manual with new fees
07/06/05	PASSPORT	Summit notes from Missoula and Kalispell
07/08/05	Physicians, Mid-Level Practitioners, Public Health Clinics,, FQHCs, RHCs, Hospital Inpatient and Outpatient, and IHS	Notice regarding Vaccines For Childre (VFC) update
07/08/05	Dialysis Clinics	New Dialysis Clinic Services manual
07/08/05	Hospital Inpatient	New Hospital Inpatient Manual

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Key Contacts

Provider Information website: http://www.mtmedicaid.org
ACS EDI Gateway website: http://www.acs-gcro.com
ACS EDI Help Desk (800) 624-3958
Provider Relations
(800) 624-3958 (In Montana)
(800) 442-1837 (Helena and out-of-state)
(406) 442-4402 Fax
TPL (800) 624-3958 (In Montana)
(406) 443-1365 (Helena and out-of-state)
(406) 442-0357 Fax
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 624-3958
Prior Authorization
DMEPOS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

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P.O. Box 4936
Helena, MT 59604

Claims Processing
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